United States General Accounting Office

GAO

Testimony

Before the Committee on Finance
United States Senate

For Release on Delivery
Expected at
10:00 a.m.,
Wednesday,
October 13, 1993

1993 GERMAN HEALTH REFORMS

Initiatives Tighten Cost Controls

Statement of Janet L. Shikles,
Assistant Comptroller General,
Human Resources Division

058379/150175

GAO/T-HRD-94-2

SUMMARY

In 1993, Germany, concerned about sharp increases in health insurance premiums deducted from payments to workers and retirees, instituted reforms to tighten existing cost-control measures. Because Germany also provides universal health care through employment-based financing, examining the recent German experience is instructive as Congress deliberates health care reform options for the United States.

Before 1993, Germany had budget caps for the physician and hospital sectors that were negotiated between the associations representing providers and the sickness funds, funds that provide health insurance to most Germans. The initial thrust of the reforms was that the government has imposed mandatory global budgets for 3 years. These generally limit the growth of expenditures in the physician and hospital sectors to the rate of increase of the revenues of the sickness funds. Global budgets were also instituted for the first time on the pharmaceutical and dental sectors. The government's goal is to stabilize contribution rates and save over $6 billion the first year.

Additional cost-containment measures are in various stages of development. These are expected to reduce continued reliance on mandated global budgets. They include the following:

Hospitals--Changing from per diem payment for patients to prospective budgeting with specified rates for some procedures.

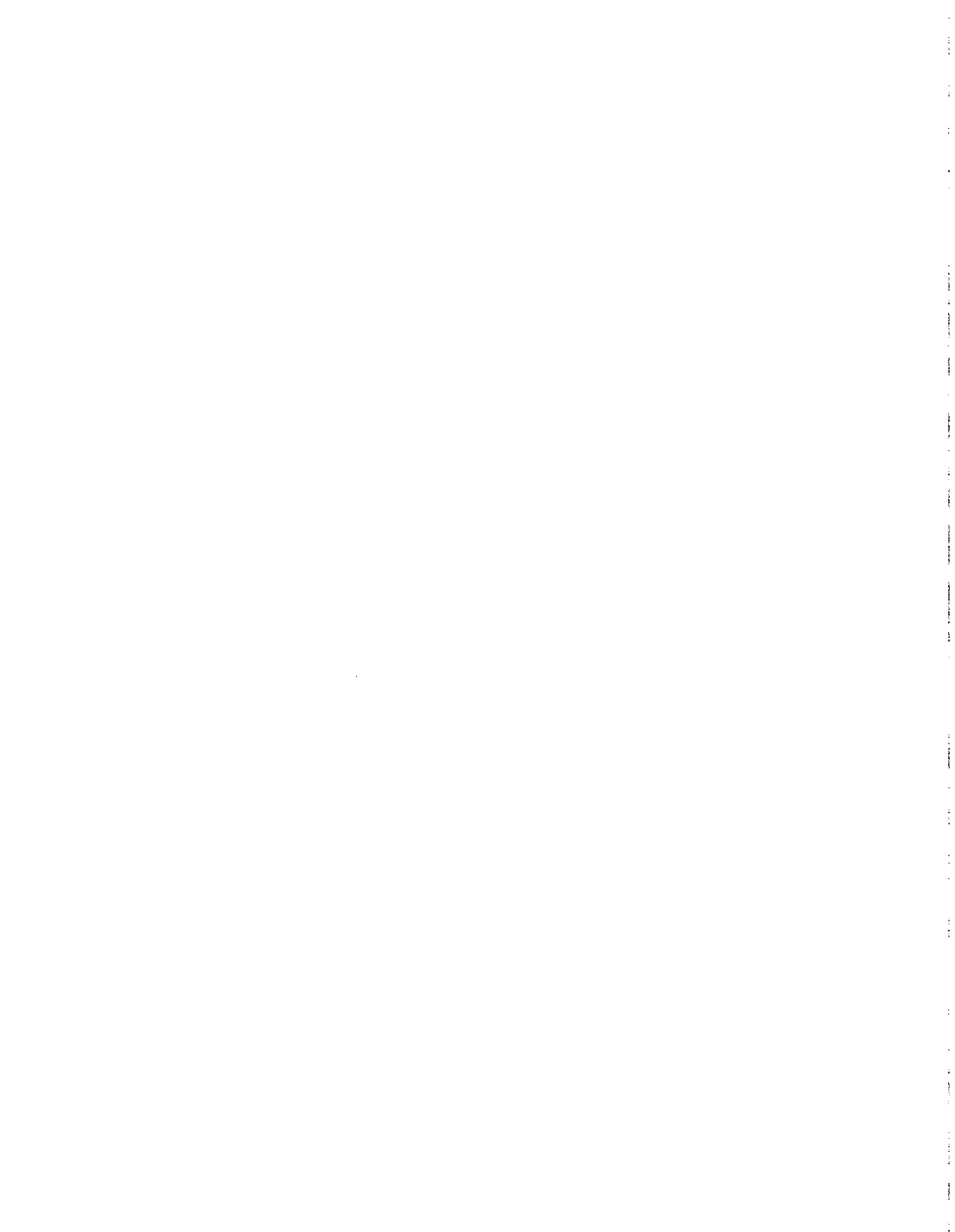
Physicians--Limiting the number of physicians permitted to practice in the sickness funds. Attempt to increase the percentage of primary care physicians through increased reimbursement.

Prescription Drugs--Establishing a global budget, initially set at the 1991 expenditure level, with prescribing physicians and drug companies financially liable for exceeding the budget.

Dentists--Reducing reimbursement for certain services and for all services in excess of average volume for a practice.

Germany also is attempting to increase competition between sickness funds by giving workers a greater choice of funds and narrowing the difference in contribution (premium) rate assessed by the different funds.

Although the effects of the reforms cannot yet be fully assessed, early indications are that expenditures are being reduced. For the first 6 months of 1993, average cost per sickness fund member fell by 2.7 percent compared with a 9.2-percent increase last year. Some critics, however, assert that the quality of care will be compromised as costs are squeezed.



Mr. Chairman and Members of the Committee

I am pleased to be here to testify on the approaches used by the German health care system to control the growth in health care costs while still assuring universal coverage. Recently, your Committee held a hearing on factors driving the costs of health care in the United States. Expensive new technologies, an aging population, administrative waste, structural inefficiencies, and the need to reduce unnecessary procedures are factors underlying health care cost increases in most industrialized nations.

My testimony is taken in large part from our report issued this July, which focuses on the recent measures taken by Germany to address these cost pressures.[1] Germany's experience is instructive for the United States because its health care system provides coverage for nearly all residents, guarantees a generous benefit package, and, like the U.S. system, relies primarily on employment-based financing. Germany also has been able to keep its share of gross domestic product (GDP) spent on health care relatively constant over the past decade, in sharp contrast to the United States where health spending has increased from 9.3 percent of GDP in 1980 to about 14 percent today.[2]

Even so, German health care costs have been rising faster than inflation. In addition, its health care system's most important and visible source of funding--mandated employer and employee payments for health insurance coverage--rose sharply in the past 2 years, from 12.2 percent of the wage base in 1991 to 13.4 percent at the beginning of 1993.

To prevent any further increase in this mandated contribution rate, Germany responded in December of 1992 with tough new legislation that:

-- imposes mandatory global budgets for the next 3 years for the physician, hospital, prescription drug, and dental services sectors;
-- constrains the supply of physicians and adds incentives to change specialty mix;
-- constrains the supply of new technologies;

---

[1]See 1993 German Health Reforms: New Cost Control Initiatives (GAO/HRD-93-103, July 7, 1993). The report provides a more thorough discussion of Germany's recent health reforms.

[2]See Health Care Spending: The Experience of France, Germany, and Japan (GAO/HRD-92-9, Nov. 15, 1991). The report provides a more thorough discussion of the cost-containment efforts pursued by Germany during the 1970s and 1980s.

-- substitutes outpatient hospital care for more expensive inpatient care;
-- increases emphasis on preventive care; and
-- expands consumer choice of sickness funds and reduces differences in premium rates among these health insurance funds.

The mandatory global budgets are already in effect and are expected to generate about Deutsche Mark (DM) 10 billion[3] (about 6 percent of 1992 expenditures) in savings. The structural reforms affecting hospitals, providers, and insurers are being developed and phased into the German health care system over the next several years to achieve continuing cost savings with less reliance on fixed global budgets in the future. These changes clearly echo many of the proposed remedies suggested for reforming the U.S. health care system.

The following sections of this testimony provide an overview of the German health care system, discuss problems leading up to the 1993 reforms, and present some early results of these changes.[4]

OVERVIEW: SICKNESS FUNDS PROVIDE COVERAGE FOR MOST GERMANS

Germany's health care system provides nearly universal insurance coverage for a comprehensive range of health services and has a better record than the United States in constraining the growth of health care costs. Since 1980, Germany has been able to stabilize health spending at less than 8.9 percent of GDP while U.S. spending escalated from 9.3 to 13.5 percent of GDP.

Most Germans obtain their health insurance through membership in one of about 1,200 so-called sickness funds. This year, virtually all Germans with salary or wage income below the equivalent of about $41,000 have been compelled to join one of these sickness funds. Workers above the income threshold can voluntarily join a

---

[3]Using an exchange rate of 1.58 DM per U.S. dollar, this amounts to about $6.3 billion.

[4]While the former West German health care system now covers the entire country, this testimony focuses on conditions that existed and changes occurring in former West Germany, which provide a better basis for comparison with the United States.

sickness fund and many do so.[5] The sickness funds also provide coverage for most retirees, the unemployed, and the disabled.

German law requires the sickness funds to provide a comprehensive benefits package that covers most health care costs with little or no copayment by members. Presently, the sickness funds do not cover long-term nursing home care, but some allowances are made for home care.

Government-mandated contributions, shared equally by workers and sickness funds, primarily finance the nonprofit sickness funds. The premium contribution operates much like a payroll tax where a fixed percentage of the employee's gross compensation is deducted from each paycheck and transferred directly to a nonprofit sickness fund. The 1993 contribution rate has averaged 13.4 percent of wages up to a statutory income ceiling, shared equally between employer and employee, with substantial variations from fund to fund. Under this system, premiums reflect the income of the worker and all workers in the same fund pay at the same contribution rate regardless of health status, age, or family size.

German citizens are free to choose their own physician for ambulatory care. Nonemergency hospital care requires referral by an office-based physician. These physicians are generally not allowed to provide treatments to their patients in the hospital setting. Inpatient care is provided by hospital-employed physicians who conversely may not typically treat patients outside the hospital.

The sickness funds reimburse office-based physicians on a fee-for-service basis and hospitals on a per diem basis. Nationwide associations of office-based physicians and sickness funds negotiate relative point values for all services. Office-based physician reimbursement is determined from a fee schedule negotiated between the associations of sickness funds and physicians. Before the 1993 reforms, daily rates for each hospital, determined from previous service utilization, were negotiated annually between each hospital and those sickness funds insuring at least 5 percent of the hospital's patients.

---

[5]Only about 10 percent of Germans are not members of one of these sickness funds; about half of this group have incomes above the statutory ceiling and choose to purchase private insurance. Most of the rest are civil servants and public employees who participate in a special plan that covers 50 to 80 percent of their health care costs and is often augmented to 100-percent coverage by supplemental plans purchased from private insurers.

EARLIER COST-CONTAINMENT EFFORTS ESTABLISHED FRAMEWORK FOR 1993 REFORMS

The German health care system has evolved since its inception to meet changing demographic and economic circumstances as well as shifts in political power. Since the mid-1970s, health care reform concentrated on stabilizing contribution rates by linking increases in expenditures in some health care sectors to the revenue growth of the sickness funds; that is, basing increases on changes in the gross wages and salaries of the members.

In 1977, federal law established Concerted Action, a biannual assembly of major players in the health care system, to develop broad guidelines for the nation's health care system. Concerted Action first set budget targets for regional associations of physicians though these targets were benchmarks or guidelines and not legally binding. In addition, reforms included a national relative-value fee schedule as a prerequisite of meeting the budget targets. These early reforms lacked any regulations affecting cost containment in the hospital sector, although some cost-sharing occurred in the dental and pharmaceutical sectors. The targets set by Concerted Action in the 1980s have been credited with setting boundaries within which negotiations between the sickness funds and the physician associations and hospitals occurred.

Capped Budgets Control Physician But Not Hospital Spending

The limited success of these expenditure targets spurred new reforms in the 1980s to place expenditure caps on the budgets of the regional associations of physicians and budgets for each hospital. Budgets also were negotiated between each hospital and the sickness funds using, in part, prior utilization rates with a small reduction in the reimbursement level of excess hospital days. In addition to these expenditure caps, these reforms shifted some costs to patients by introducing copayments and also instituted quality assurance measures. Our earlier work on German reforms indicated that the tougher budget controls on physician spending were successful in reducing real spending by as much as 17 percent between 1977 and 1987. Hospital budget controls, however, failed to contain spending because capital costs were excluded and a formal mechanism to insure compliance was lacking.

Impetus for 1993 Reforms

Public pressure to stabilize contribution rates as well as an awareness that structural change was needed to reduce excess utilization and rigidities in the system forced the adoption of the 1993 reforms. Health care observers in Germany identify several conditions that, in addition to a slowdown of the economy and the high cost of reunification, laid the groundwork for these changes.

-- Growing public frustration with increases in the mandated contribution, which escalated from 12.2 to 13.4 percent of wages and salaries between 1991 and January 1993.
-- Serious inequities caused by growing differences in contribution rates among sickness funds with differing member characteristics.
-- Concerns that escalating sickness fund contribution rates were jeopardizing the financial standing of the pension system and the competitiveness of German industry through effects on already high labor costs and prices of products.
-- Expenditures for both prescription drugs and dental services were rising too rapidly because these services had no effective controls on either volume or price.
-- Expenditures in the hospital sector were excessive due to a lack of incentives to control costs. Past reforms to improve hospital management were not very effective because of states' reluctance to close hospitals and physicians' reluctance to alter referral patterns.

Thus, by 1992, German health officials had concluded that the political risk of federal intervention to introduce strong measures to stabilize contribution rates was less than the risk of doing nothing.

TEMPORARY MANDATORY GLOBAL BUDGETS DESIGNED TO CONTROL SPENDING

The German Health Care Structure Reform Act of 1993 is considered the most significant system reform in the past 50 years. The act temporarily linked growth in existing global budgets for office-based physicians and hospitals to the revenue growth of the sickness funds. The act also extended global budgets to the pharmaceutical and dental care sectors and temporarily linked them to the revenue growth of the sickness funds. Finally, it enacted a series of structural reforms to be implemented while the temporary budget controls were in place. Overall, these reforms significantly increased federal intervention in managing the German health care system.

The government expects these nonnegotiable budgets on major health care sectors to stabilize contribution rates over the next 3 years. To stay within these budgets, charges for most physician and dentists services, prescription drugs, and hospital fees will decrease; contribution rates to the sickness funds will not increase. The new reforms aim to produce a net savings to the Statutory Health Care system of DM 10 billion (about $6.3 billion) the first year. This saving represents about a 6-percent reduction in the total 1992 sickness fund expenditures. While controlling most areas of health spending more tightly, the 1993 reforms do permit increases in spending for preventive care and surgery in an

ambulatory setting. These increases are expected to reduce demands for more expensive treatments.

The act also provides for the development of several structural health system reforms to be phased in over the next few years. The reforms would reduce pressures for cost growth and eliminate the need for federally imposed caps. The self-governing associations of health care providers and payers will implement these reforms and will have considerable freedom in deciding how to accomplish them.

REFORMS IN THE PHYSICIAN SECTOR

Under the 1993 reforms, total spending by sickness funds for office-based physician services will not be permitted to grow faster than sickness fund revenues. While the emergency budget cap is in place, the Ministry of Health will implement a number of controversial structural reforms to reduce incentives for excess utilization of physician services and to constrain the supply of some physician specialties.

The 1993 reforms aim to reduce excess service volume and overuse of technical services by physicians who are authorized to treat sickness fund members. To enforce the act, representatives from the regional associations of physicians and sickness funds plan to continue to oversee billing activity, but will impose stricter financial sanctions against those physicians who exceed average service volumes and prescribing levels. Physicians who exceed their expected prescribing levels by more than 15 percent will be reviewed and those exceeding the average by 25 percent will be financially penalized unless they can justify the increases. The reforms also encourage the suspension of remuneration for services provided with high-cost medical equipment that is installed without prior authorization.

Reforms Affecting Physician Supply

Germany is also implementing reforms that will contain the number of physicians eligible to practice in the sickness funds as well as change the specialty and geographic distribution of the physicians already practicing in the system. The Federal Ministry of Health contends that Germany has an oversupply of physicians and that it has too many specialists relative to the number of primary care physicians. This, the Ministry asserts, has contributed to an increase in services rendered and, thus, costs.

To contain the number of physicians and change their geographic distribution, the new act requires the establishment of physician-to-population ratios. The Federal Association of Sickness Fund Physicians and the sickness funds have until 1999 to develop and implement a system for allocating physicians on the basis of the

needs of the population and the availability of medical care. To change the specialty distribution of physicians, German health officials are relying on economic incentives to make practicing as a primary care physician more attractive.

REFORMS AFFECTING THE HOSPITAL SECTOR

The 1993 reforms attempt to mitigate shortcomings in the budgeting and planning of the hospital sector by reducing incentives for excess utilization and previous disincentives to efficiency. The new act requires that the hospital sector move away from paying a fixed amount for each day a patient is in the hospital, which encourages longer hospital stays and higher costs, to a prospective budgeting system, which establishes specific rates for individual procedures and conditions. While the new system is being developed, each hospital will be required to stay within global budgets negotiated with the sickness funds, with any budget increase directly linked to revenue growth in the sickness funds and new wage settlements.

To reduce duplicative and unnecessary patient care between the office-based physician sector and the hospital, hospital physicians will be allowed to perform some outpatient treatments and surgeries. Before the 1993 reforms, the sharp division between hospital- and office-based physician treatment produced higher health care costs for the sickness funds because the funds often paid for duplicative tests and excessively long hospital stays.

PRESCRIPTION DRUG REFORMS

Germany now sets a mandatory global budget on total pharmaceutical spending. In the absence of budget controls in the past, costs have escalated in this sector. In fact, in 1988 Germany spent more per person for prescription drugs than the United States, where total health care costs per person have been nearly twice those of Germany.

The new act imposes a 1993 global budget for pharmaceuticals fixed at the expenditure level for drugs prescribed by sickness fund physicians in 1991. To compensate for the cost of drugs introduced since 1991, the law mandates a 5-percent reduction for prescription drug prices not previously lowered by reimbursement policies and a 2-percent price reduction in over-the-counter drugs. These mandated price reductions will be in effect for the next 2 years.

The global budget will be enforced by holding the Federal Association of Physicians and the pharmaceutical industry responsible for spending above this global budget. Physician fees for 1994 will be lowered to offset the first DM 280 million in potential overruns. The pharmaceutical industry will have to cover additional overruns up to a further DM 280 through lowered drug

prices. The sickness funds will be responsible for overruns greater than DM 560 million. Physicians who exceed these standards by specified percentages may be penalized. Beginning in 1994, the physician associations and sickness funds will negotiate regional prescription drug budgets on the basis of prescription cost standards. These measures are expected to produce acceptable pharmaceutical expenditures in place of a federally mandated prescription drug budget in 1994. In addition, patient copayments for drugs will increase in 1994 and be directly linked to the quantity of drugs prescribed.

DENTAL SERVICES REFORMS

The lack of global budgeting in the dental care sector and high dental fees, among the highest in the European Community, prompted the setting of mandatory budgets on this sector that are again linked to revenue growth in the sickness funds. In addition, the 1993 reforms impose a 10-percent reduction for dentures and orthodontic treatments, and a 5-percent reduction in reimbursements to dental technicians. Further, the act will reduce reimbursements for all dental services in excess of the average volume for a practice and for dental prostheses considered medically unnecessary.

REFORMS AIM TO REDUCE DISPARITIES AMONG SICKNESS FUNDS AND ALLOW GREATER CHOICE

The 1993 reforms also aim to reduce disparities among sickness funds. Variations in required contribution rates range from 8.5 to 16.5 percent, even though the members receive the same benefits. In addition, the Federal Ministry of Health plans to provide members with greater choice among sickness funds. The government expects these changes to narrow the range of contribution rates while still allowing some differences, to account for more efficient management.[7] This rate-equalization process will transfer resources among sickness funds based on four adjustment factors: the individual sickness fund's payroll tax base, number of insured dependents, and age and sex composition.

Closing the gap in contribution rates among sickness funds will particularly help statutory local sickness funds, which presently have contribution rates above the national average. Mandated memberships contribute to differences in contribution rates because

---

[7]As of January 1, 1996, substitute funds must open membership to everyone. Sickness funds will be allowed to consolidate and local funds that are no longer efficient can be closed. In addition, minimum membership size for forming a sickness fund will be increased to 1,000 (up from 450).

some sickness funds have members with higher actuarial risks. For example, many local sickness funds, because they must enroll all those who are not otherwise insured, tend to have higher health risk members, including the elderly, blue-collar workers, and the sick. Because care for these individuals costs more and they tend to earn less, the contribution rates must be fairly high to cover all health care costs.

The 1993 reforms also give German workers greater flexibility in their choice of sickness fund. By January 1, 1997, most Germans will be allowed to choose their sickness fund each year. This freedom of choice is expected to motivate sickness funds to provide a broader range of services, such as health promotion, and be more administratively efficient. Some of the sickness funds maintain that they will be able to attract new members through improved services. However, opinions vary on how much competition will exist among the funds given the comprehensive nature of the mandated benefits, limits on administrative allowances for individual funds, and reduced variation in contribution rates.

EARLY EFFECTS OF 1993 REFORMS

The effects of the 1993 health care reforms cannot be fully assessed at this stage, but some early indicators suggest progress in curbing expenditure increases despite sometimes intense protests from the health care community. Germany's Federal Health Ministry announced that the average cost per sickness fund member fell by 2.7 percent in the first 6 months of 1993 compared with a 9.2-percent increase in 1992 (see table 1). Pronounced declines were registered for prescription drugs and dental prostheses--two sectors where global budgets were introduced for the first time. Physician and hospital spending continued to increase but at rates substantially below 1992 rates and slower than the increase in sickness fund revenues per member. If this performance can be sustained, Germany will reach its objective of keeping sickness fund expenditures below the rate of increase in the wage base even if the substantial reductions in spending on drugs and dental prostheses taper off.

Table 1: Costs per Sickness Fund Member (Including Retirees)

Service	Percent change 1992	Percent change, first 6 months of 1993
Physician services	6.7	2.1
Dentist services	1.0	-2.0
Dental prostheses	20.2	-32.5
Prescription drugs	1.0	-20.6
Hospitals	8.0	3.8
Total reimbursement for services[a]	9.2	-2.7
Sickness fund wage base (revenue base)	5.1	4.7

[a]Includes additional categories, such as durable medical equipment, ambulance services, and other health related services.

Source: German Federal Ministry for Health (Sept. 1993).

The percentage decrease in expenditures for prescription drugs has already tapered off from the 25-percent decline recorded in the first 2 months of the year.

Responding to advice from the regional associations of physicians, physicians have sharply reduced prescribing brand-named drugs and less useful medications to avoid any penalty for exceeding the mandated pharmaceutical budget. In doing so, however, some physicians have suggested that adequate medical care is no longer guaranteed for sickness fund members. The sickness funds consider this reduction justifiable because it represents a reduction in prescriptions for less efficacious drugs and a movement toward greater use of less expensive generic drugs. The Ministry of Health also contends that about 20 percent of the reimbursed drugs were wasted by patients because of previous problems with the way drugs were dispensed.

Most health care providers initially denounced the proposed legislation as an end of the traditional German health care system and the beginning of "socialized medicine." Physicians have also announced their intentions to ask for a ruling by the federal constitutional court on limiting the number of physicians and dentists authorized to treat sickness fund members. Representatives of the dentist associations threatened to terminate

cooperation with the sickness funds and indicated that growing numbers of accredited providers might withdraw from the system. However, according to a Ministry of Health official, since passage of the act, the health care industry has accepted most of the new requirements.

Despite the protests of some groups, the Ministry of Health is already considering another round of structural reforms. The Ministry instructed the expert council to the Concerted Action committee to submit preliminary suggestions by December 1993 on further restructuring the health care system, with a final proposal due by the end of 1994. The Ministry contends that while the 1993 cost-cutting measures appear successful, additional reforms will be necessary to address demographic changes, trends in major diseases, and the introduction of new medical technologies.

POTENTIAL IMPLICATIONS FOR U.S. HEALTH REFORM

The recent German reforms illustrate the continuing cost pressures facing the health care systems of other industrialized nations; indeed, health care costs continue to grow faster than general inflation rates in all countries (see app. I). Despite an enviable record of cost containment and universal coverage, the German government found that it had to embark on a series of significant reforms to its health care system to further contain costs.

These reforms build on two decades of changes to the German health care system that have helped Germany control health care costs better than most other industrialized nations. Its universal coverage and well-organized administrative mechanism, which make it easier to monitor provider fees and service utilization, enhance Germany's ability to respond to changing health market conditions.

The United States should carefully monitor Germany's past experience and current reforms using global budgets, physician fee schedules, and constraints on resource growth as they unfold over the next 3 years. We may gain insights into their feasibility and applicability to our nation's reform process. Germany's experience in refining, changing, and adapting some of the same tools being considered in U.S. reform proposals also underscores the dynamic nature of the health care market. Perhaps one of the most important lessons from the German experience is that health care reform is a continuous process and that as the United States moves toward comprehensive health care reform it should incorporate enough flexibility in its system to ensure responsiveness to a constantly changing health market.

Mr. Chairman, this concludes my testimony. I will be pleased to answer any questions you may have.

AVERAGE ANNUAL PER CAPITA GROWTH RATE IN TOTAL HEALTH EXPENDITURES, ADJUSTED FOR INFLATION

Country	Percent growth (1980-91)
Sweden	0.46
Ireland	1.17
New Zealand	1.28
Denmark	1.59
Netherlands	1.77
Switzerland	1.98
Germany	1.99
Australia	2.33
Austria	2.51
Greece	2.63
Turkey	2.72
United Kingdom	3.27
France	3.29
Luxembourg	3.42
Norway	3.43
Iceland	3.54
Belgium	3.55
Japan	3.70
Italy	3.75
Portugal	4.04
Spain	4.12
Canada	4.19
United States	4.61
Finland	4.83

Source: OECD health data.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1000
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000
or by using fax number (301) 258-4066.

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548

Official Business
Penalty for Private Use $300

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100